

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3819

## CERTIFICATE OF DEATH

03762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	
c. LENGTH OF STAY IN 1b <u>LIFETIME</u>		d. STREET ADDRESS <u>1 MAIN ROAD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HIS LATE HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M</u> Last <u>BECKETT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-20-1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>9</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BECKETT</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE FIELDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MARY BECKETT</u> Address <u>CHANCE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3-1-60</u> , 19 <u>60</u> , to <u>3-4-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-4-60</u> , 19 <u>60</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D. <u>Princess Anne, Maryland</u>		DATE SIGNED <u>3-7-60</u>	
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR-8-1960</u>	
22c. NAME OF CEMETERY <u>ST. CHARLES</u>		22d. LOCATION (City, town, or county) <u>CHANCE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Webster</u> ADDRESS <u>Deal Island</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

2719

DE. 11 12 1901

WILLIAM B. COLE

WILLIAM B. COLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3816

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03763

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mariners Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>HOLLAND</b> Last <b>BLADES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John Holland</b>				14. MOTHER'S MAIDEN NAME <b>Julia Lankford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Avalon Riggins--E. Chesapeake Ave.--Crisfield Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b> DUE TO (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile Degeneration</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> 19 <b>53</b> to <b>3/5</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> 19 <b>60</b> and that death occurred at <b>8:00 P.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>A. N. Barr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>				22d. ADDRESS <b>Main St.--Crisfield, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mariners Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

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page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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M  
3820  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03764

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Somerset</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>              |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>   |                               | c. LENGTH OF STAY IN 1b <b>Lifetime</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D.</b>   |                               | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>ASBURY</b> Last <b>CLUFF</b>   |                               | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>6</b> Year <b>1960</b>   |                                       |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>July 28, 1873</b> |
| 9. AGE (In years last birthday) <b>86</b> yrs.   |                               | 10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farming</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Marion Station, Md.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |                                       |
| 13. FATHER'S NAME <b>George I. Cluff</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Margaret Coulbourne</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |                                       |
| 17. INFORMANT <b>Mrs. Thomas Riggin--Marion Station, Md.</b>   |                               | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Dil? Heart Arteriosclerosis</b><br>592X DUE TO <b>Chronic Dil? reglu. Chole. reglu. reglu.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic Dil? reglu. Chole. reglu. reglu.</b><br>DUE TO (c) <b>Chronic Dil? reglu. Chole. reglu. reglu.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arterio Sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                       |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                               |  |                                       |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |                               |  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               |  |                                       |
| 20f. (City or town) (County) (State)   |                               |  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1957</b> to <b>Mar. 6, 1960</b> that (I) (we) last saw the deceased alive on <b>Mar. 6, 1960</b> and that death occurred at <b>2:35 A.M.</b> from the causes and on the date stated above.  |                               |  |                                       |
| 22a. SIGNATURE <b>George C. Coulbourn</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED  |                               |  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M.D.</b> 22d. ADDRESS <b>Marion Station, Md.</b>  |                               |  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Mar. 8, 1960</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Baptist Cemetery</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Rehobeth, Md.</b>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>  |                               | 25a. REC'D BY REGISTRAR <b>MAR 14 60</b> DATE  |                                       |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>  |                               |  |                                       |

LETTERS TO THE EDITOR

1950

Dear Sir,

I have the pleasure to inform you that your letter of the 15th inst. has been received.

The matter is being considered and a reply will be sent to you as soon as possible.

Yours faithfully,

W. J. G. [Signature]

Director, [Institution]

10, [Address]

[City]

[Country]

[Postcode]

[Phone Number]

[Fax Number]

[Email Address]

[Website]

[Social Media]

[References]

[Bibliography]

[Footnote]

[Appendix]

[Index]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03765

Reg. Dist. No.

3821

|   |                                  |  |  |  |  |   |   |
|---|----------------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Somerset</u> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Oriole</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>59 years</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>X Oriole</u>                                    |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  |  |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Vernon</u> Middle <u></u> Last <u>Davis</u>   |                                  |  |  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>24</u> Year <u>19 60</u>   |  |   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept. 29, 1900</u>  |  | 9. AGE (In years last birthday)<br><u>59 yrs.</u>   | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryl and</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Thomas Davis</u>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Kathryn Davis</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u></u>   |  | 17. INFORMANT<br><u>Mr Thomas Davis Oriole, Md.</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u><br><u>592X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Chronic Nephritis, Cephitis,</u><br>(c) <u>Prostatic Hypertrophy -</u>   |                                  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>0</u><br><u>mouth</u><br><u>mouth</u>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Epileptic for years -</u>   |                                  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Hour <u></u> a. m. <u></u> p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |  |  |  |  |   |   |
| ACTUAL SIGNATURE <u>R.H. Johnson</u> M.D.   |                                  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| EXAMINER'S NAME (Type) <u>R.H. Johnson</u>  |                                  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
|   |                                  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 25-1960</u>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>  |                                  | 22b. DATE THEREOF<br><u>3-27-60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Oriole Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Oriole, Maryland</u>                          |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Levin R. Wilson</u>  |                                  |  |  | ADDRESS<br><u>Princess Anne, Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 1 '60</u>  |   |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Hines</u>   |  |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Medical Examiner's Certificate of Death

1

1

3822

3822

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03766

Reg. Dist. No.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Somerset</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b>   |  | c. LENGTH OF STAY IN 1b <b>life</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b> |  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>William C. Griffith</b>  |  | 4. DATE OF DEATH <b>Mar. 19 1960</b>  |  | 5. SEX <b>male</b>  |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>April 19, 1881</b>   |  |
| 9. AGE (In years and birth day) <b>78</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |  |  |
| 13. FATHER'S NAME <b>William J. Griffith</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Kathryn Clayville</b>   |  |   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>217-36-1752</b>  |  |   |  | 17. INFORMANT <b>Mrs. Annie Griffith Princess Anne, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized and coronary arteriosclerosis</b> |  |   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |  | 20f. (City or town) (County) (State)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that I attended the deceased from <b>Jan 1958</b> , 19____, to <b>3-18-60</b> , 19____, that I last saw the deceased alive on <b>3-18-60</b> , 19____, and that death occurred at <b>7A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>3-20-60</b>  |  |   |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Everett C. Sutter</b>   |  |   |  | PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |   |  | 22b. DATE THEREOF <b>3/21/60</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Hannon</b>   |  |   |  | ADDRESS <b>Princess Anne, Md.</b>   |  | 24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hannon</b>   |  |  |  |

*[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. Discernible fragments include:]*

*[Faint header area]*

*[Faint body text, possibly containing names and dates]*

*[Faint footer or signature area]*

3823

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>SOMERSET</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b><br>c. LENGTH OF STAY IN 1b <b>88 YRS.</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>SOMERSET</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b><br>d. STREET ADDRESS <b>RFD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>SENESA</b><br>First Middle Last<br><b>HORSEY</b>   |                               | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>3</b> Year <b>1960</b>   |   |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>MAY 4, 1871</b>   |
| 9. AGE (In years last birthday) <b>88</b>  |                               | 10. IF UNDER 1 YEAR<br>Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>  | 11. IF UNDER 24 HRS<br>Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>EDGAR W. HORSEY</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>MARY E. HICKMAN</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>EWELL DAUGHERTY</b>   |                               | Address <b>CRISFIELD, MD.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Prone position following over exertion 3 weeks</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>(c) <b>Anterior MI</b> |                               |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>   |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Feb. 10, 1960, to Mar. 3, 1960</b> that I last saw the deceased alive on <b>MARCH 3, 1960</b> , and that death occurred at <b>12 NOON</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>Mar 8 '60</b>                                |                               |  |   |
| ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.   |                               | DATE SIGNED <b>Mar 8 '60</b>   |   |
| PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>   |                               | CRISFIELD, MARYLAND  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Mar. 6, 1960</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>   |                               | 24a. REC'D BY REGISTRAR <b>MAR 8 '60</b>   |   |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>  |                               |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

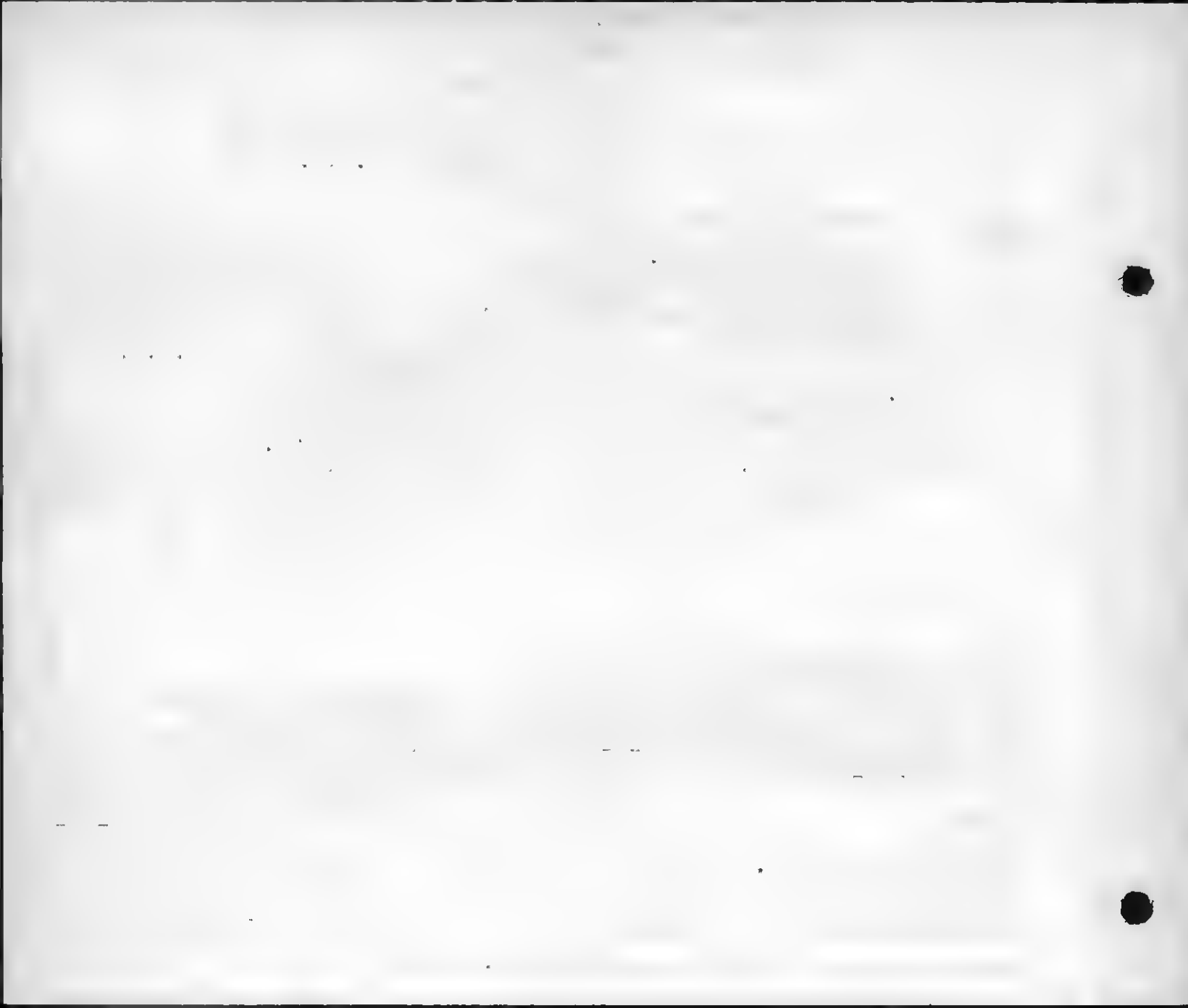
3818

## CERTIFICATE OF DEATH

03768

Reg. Dist. No.

|   |                                  |  |   |   |  |  |                  |
|---|----------------------------------|--|---|---|--|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Somerset</b> <b>MARYLAND</b>  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> |  |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Princess Anne</b>  |                                  |  |   | c. LENGTH OF STAY IN 1b<br><b>5 month</b>   |  |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Walter</b> Middle <b>W.</b> Last <b>ingersol</b>  |                                  |  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>13</b> Year <b>19 60</b>  |  |  |                  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 1, 1892</b> |   | 9. AGE (In years lost birthday)<br><b>67</b> yrs | IF UNDER 1 YEAR<br>Months Days Hours Min                           | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                      |                  |
| 13. FATHER'S NAME<br><b>John S. Ingersol</b>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Amelia Taylor</b>  |  |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Fred Taylor, Eden, Md.</b>  |  |  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Progressive spinal muscular atrophy</b>                                   |                                  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                 |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |                  |
| 20c. TIME OF INJURY<br>Hour a. <b>9</b> p. m. Month <b>19</b> Day <b>19</b> Year <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |                  |
| 21. I certify that I attended the deceased from <b>2-6-60</b> , 19 <b>60</b> , to <b>3-13-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3-12-60</b> , 19 <b>60</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Princess Anne, Maryland</b> DATE SIGNED <b>3-14-60</b><br>ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D. <b>Princess Anne, Maryland</b><br>PHYICIAN'S NAME (Type) <b>Everett C. Sutter MD</b> |                                  |  |   |   |  |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>3-15-60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Allen Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Allen, Md.</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Samuel R. Williams</b>   |                                  |  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 17 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>              |                  |



3824

## CERTIFICATE OF DEATH

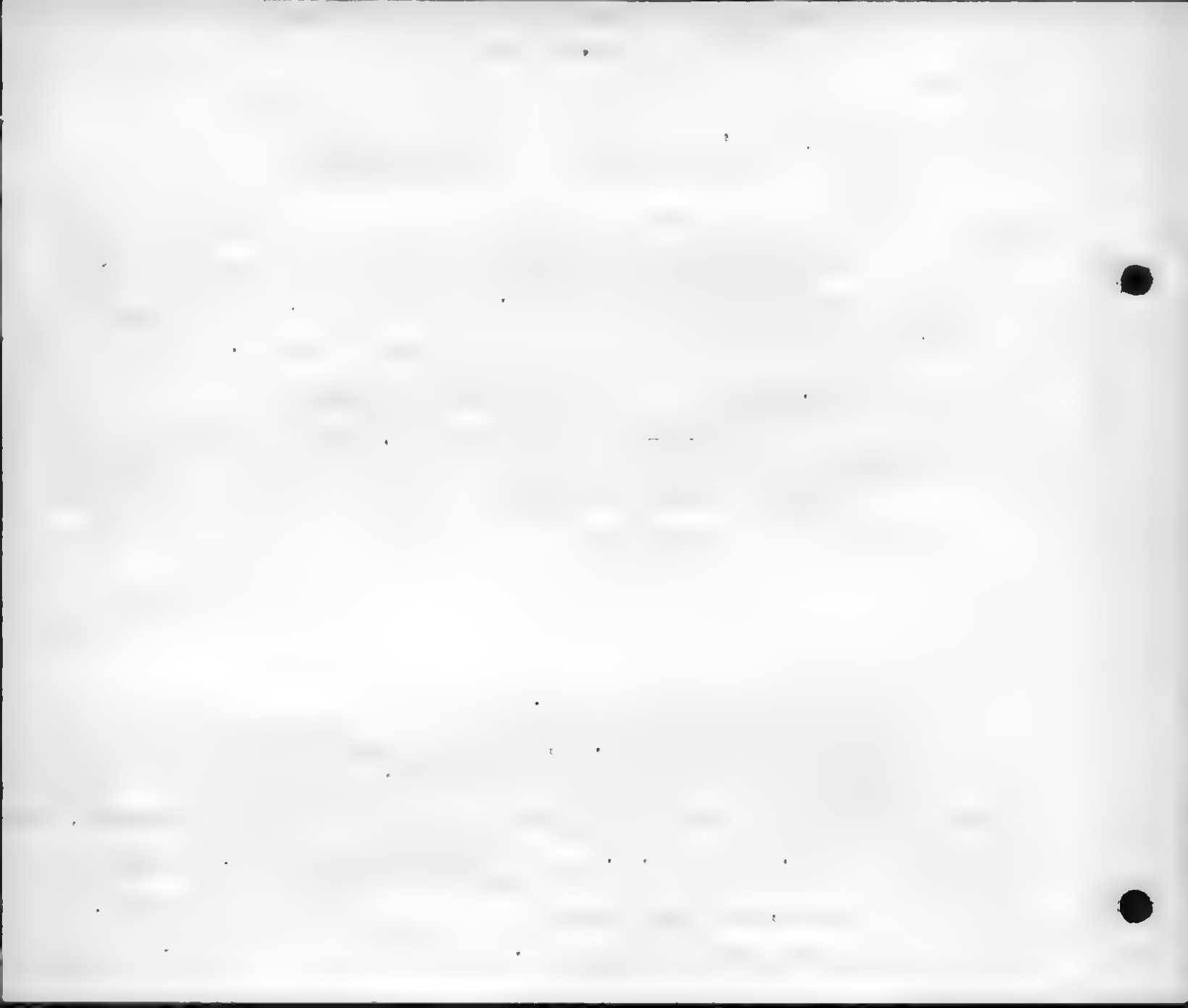
Reg. Dist. No. 7612

|  |                                  |   |  |   |   |   |  |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Somerset</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smith Island</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smith Island</b>                                     |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ewell</b>   |                                  |   |  | d. STREET ADDRESS<br><b>Ewell</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>CHARLOTTE GOULD JONES</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>March 30, 1960</b>   |   |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 12, 1888</b> |   | 9. AGE (In years last birthday)<br><b>71</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ewell, Smith Island, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 13. FATHER'S NAME<br><b>Andrew C. Tyler</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Messick</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-26-3297</b>   |  | 17. INFORMANT<br>Address<br><b>Caleb Jones, Sr.—Ewell, Maryland</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>33/X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO<br>(c) <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b> |                                  |   |  |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>   |                                  |   |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|  |                                  |   |  | 20f. (City or town)   |   | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec. 10, 1959</b> , to <b>March 30, 1960</b> , that I last saw the deceased alive on <b>March 30, 1960</b> , and that death occurred at <b>5:17 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>March 30, 1960</b>  |                                  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <i>William H. Heffner</i> M.D.  |                                  |   |  |   |   |   |  |
| PHYSICIAN'S NAME (Type) <b>William H. Heffner, M. D.</b>   |                                  |   |  | <b>Ewell, Smith Island, Maryland</b>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>April 3, 1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ewell Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Ewell, Smith Island, Md.</b>                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>ADDRESS<br><b>Bradshaw &amp; Sons—Crisfield, Md.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 1 '60</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Cirihus S. Kraus</i>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

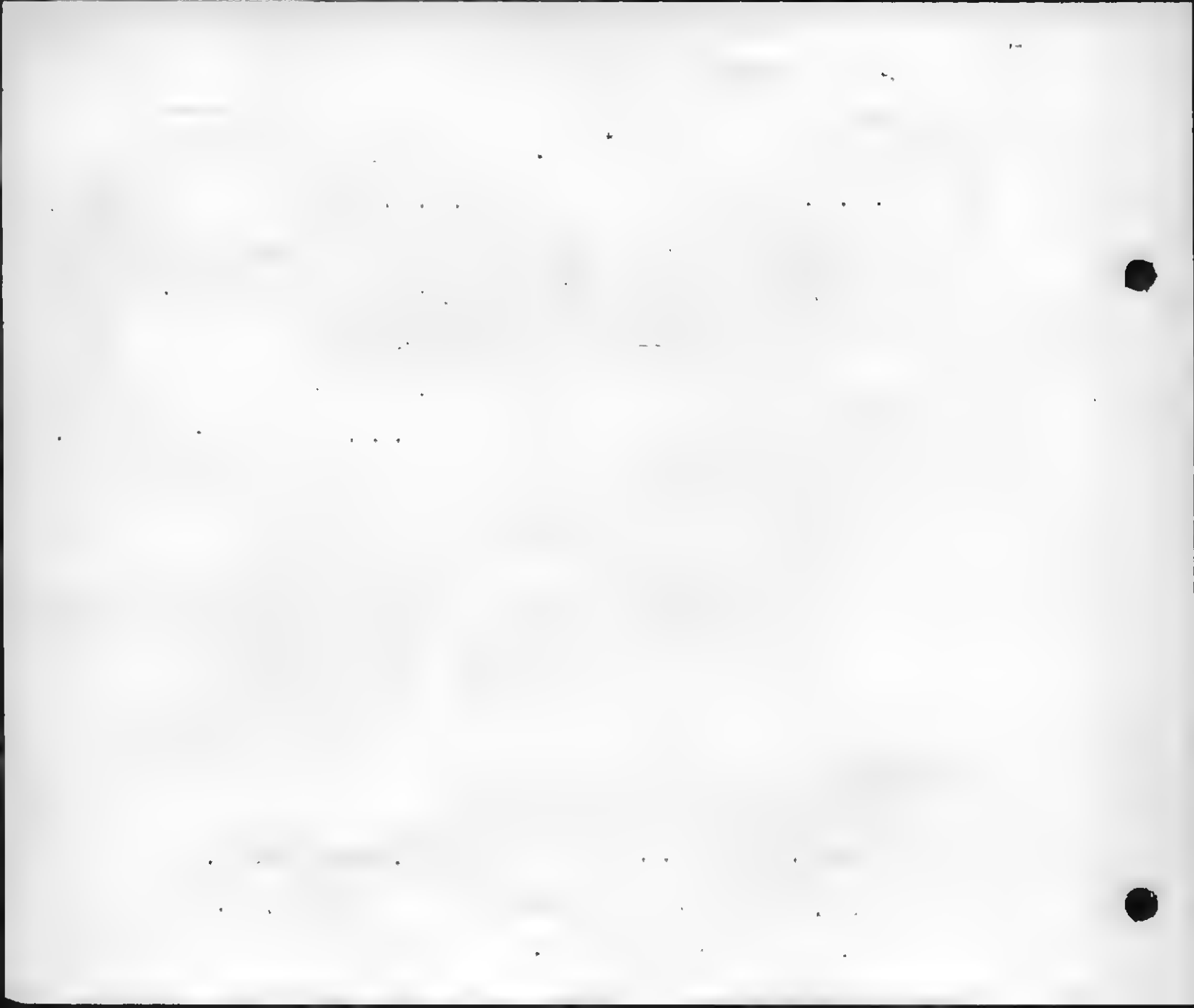
03770

**3825**

**CERTIFICATE OF DEATH**

|   |                                  |  |  |  |  |  |   |
|---|----------------------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Somerset</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Crisfield</b>  |                                  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. Lawsonia</b>   |                                  |  |  | d. STREET ADDRESS <b>R. F. D. Lawsonia</b>   |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>PAUL MANUEL STERLING LEE</b>  |                                  |  |  | 4. DATE OF DEATH Month Day Year<br><b>March 10 1960</b>  |  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 4, 1959</b>   |  | 9. AGE (In years last birthday) <b>0</b> yrs       | IF UNDER 1 YEAR: Months <b>11</b> Days <b>6</b> Hours <b></b> Min. <b></b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Crisfield, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>       |   |
| 13. FATHER'S NAME<br><b>Linwood Lee</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Peggy Sterling</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT Address<br><b>Linwood Lee--R.F.D. Lawsonia--Crisfield, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>3/10/60</b> |                                  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)               |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/10/60</u> to <u>3/10</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>60</u> , and that death occurred on <u>3/10</u> A.M., from the causes and on the date stated above.   |                                  |  |  |  |  |  |   |
| 22a. SIGNATURE <i>Sarah M. Peyton</i> M.D.  |                                  |  |  | 22b. DATE SIGNED   |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>   |                                  |  |  | 22d. ADDRESS <b>Main St.--Crisfield, Md.</b>   |  |  |   |
| 23a. BURIAL CREMATON, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town, or county) (State)      |   |
| <b>Burial</b>   |                                  | <b>Mar. 11, 1960</b>   |  | <b>Lawsonia Cemetery</b>   |  | <b>Crisfield, Md.</b>                              |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Bradshaw &amp; Sons--Crisfield, Md.</b>  |                                  |  |  | 25a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3826

CERTIFICATE OF DEATH

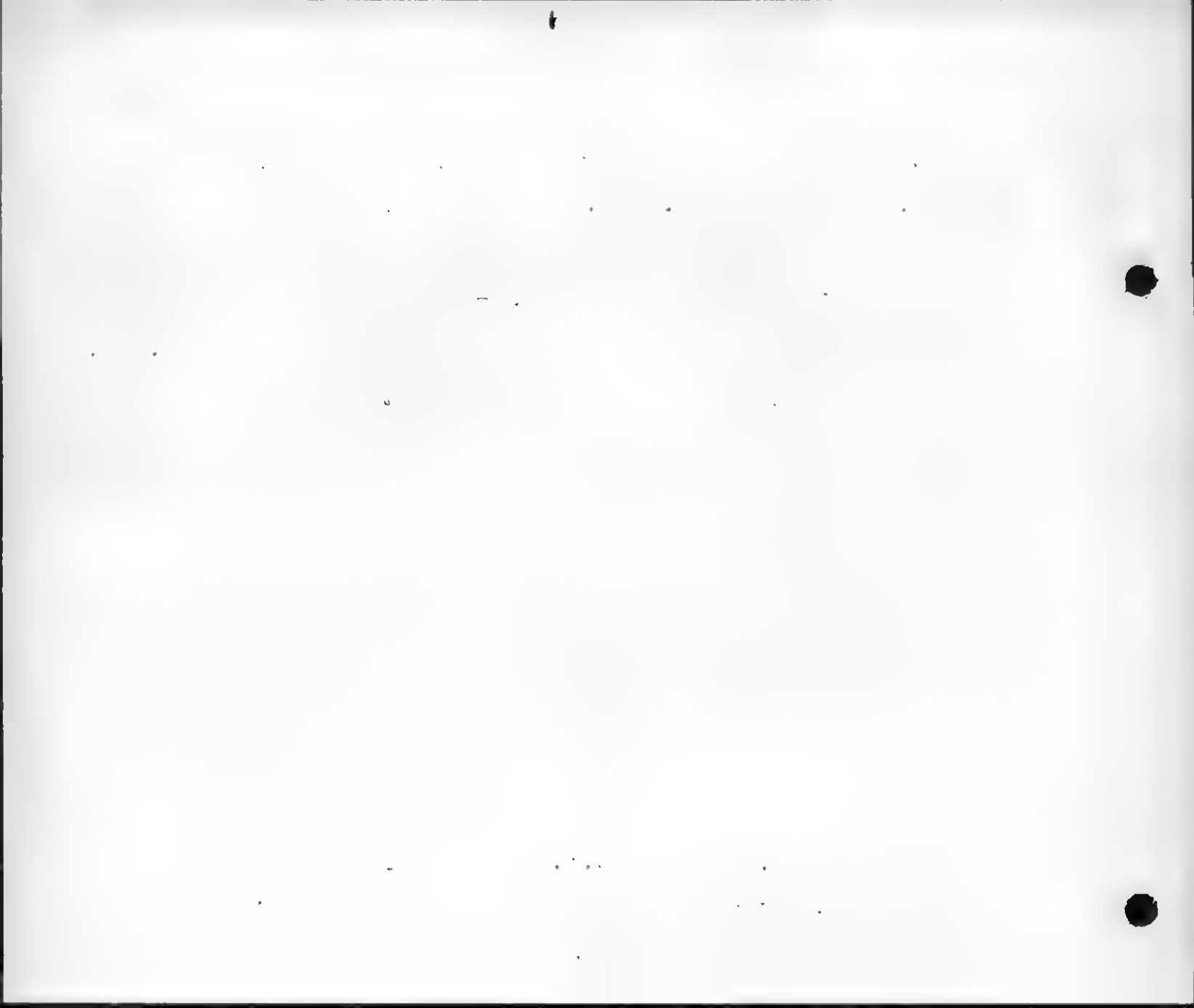
Reg. Dist. No.

03771

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>SOMERSET</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>   |   | c. LENGTH OF STAY IN 1b <b>1 DAY</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARION STATION</b>   |   |
|   |   | f. STREET ADDRESS <b>R #1, Box 238</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JEFFRY</b> Middle <b>Thomas</b> Last <b>MACK</b>  |   | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>4</b> Year <b>1960</b>   |   |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>NEGRO</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10-24-59</b>  |
| 9. AGE (In years last birthday) yrs. <b>4</b>   |   | IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b> Hours <b></b> Min. <b></b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>JESSE RICHARDSON</b>   |   | 14. MOTHER'S MAIDEN NAME <b>FRANCES MACK</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| INFORMANT Address <b>FRANCES MACK, MARION, MARYLAND</b>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b><br>DUE TO (c) <b></b> |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b></b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>3:4</b> , 19 <b>60</b> , to <b>3:4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3:4</b> , 19 <b>60</b> , and that death occurred at <b>7:35 PM</b> from the causes and on the date stated above.  |   |  |   |
| ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b></b>   |   |
| PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>  |   | <b>CRISFIELD, MARYLAND</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>Mar. 6, 1960</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Marion, Maryland</b>               |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>  |   | 24a. REC'D BY REGISTRAR <b>MAR 9 60</b> DATE <b></b>   |   |
|   |   | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>   |   |

2079202XV5

VS A15 (4)  
15M 9/58



3827

## CERTIFICATE OF DEATH

Reg. Dist. No.

03772

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| 1. PLACE OF DEATH<br>o. COUNTY <b>SOMERSET</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>  |  | c. LENGTH OF STAY IN 1b <b>32 YRS.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>   |  | d. STREET ADDRESS <b>1 MAIN STREET</b>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES C STERLING, JR.</b>   |  | 4. DATE OF DEATH Month Day Year <b>MARCH 16 1960</b>   |  |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>9-3-1927</b>   |
| 9. AGE (In years last birthday) <b>32</b> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>CLINTON STERLING</b>  |  | 14. MOTHER'S MAIDEN NAME <b>PAULINE LAWSON</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 2</b>   |  | 16. SOCIAL SECURITY NO. <b>215-20-0154</b>   |  |
| 17. INFORMANT <b>ELsie STERLING, CRISFIELD, MARYLAND</b>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Esophagus &amp; Hemorrhage</b><br><b>581.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Biliary Cirrhosis</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>2 years</b>  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>9/29</b> , 19 <b>54</b> to <b>3/16</b> , 19 <b>60</b> that I last saw the deceased alive on <b>MARCH 16</b> , 19 <b>60</b> , and that death occurred at <b>11:15 AM</b> from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <b>A. N. BARR, M.D.</b> M.D.  |  | ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>9/17/60</b>  |  |
| PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b>  |  | <b>CRISFIELD, MARYLAND</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>Mar. 19, 1960</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>   |  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR <b>MAR 21 1960</b>   |  | DATE   |  |
| 24b. REGISTRAR'S SIGNATURE <b>Robert E. [illegible]</b>  |  |  |  |

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24 hours after death. Page 4  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03773

Reg. Dist. No.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>SOMERSET</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CRISFIELD</u>  |  | c. LENGTH OF STAY IN lb<br><u>LIFETIME</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>39 CRISFIELD</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>AT HIS HOME</u>  |  |  |  | d. STREET ADDRESS<br><u>1 MAIN ST.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>FLETCHER THOMAS</u>   |  |  |  | 4. DATE OF DEATH Month Day Year<br><u>MARCH 22 1960</u>  |  |   |  |
| 5. SEX<br><u>MALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>FEB. 16 - 1885</u>   |  |
| 9. AGE (In years last birthday)<br><u>75</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND - U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>WATERMAN</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SEAFOOD</u>  |  |   |  |
| 13. FATHER'S NAME<br><u>BENJAMIN THOMAS</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>ELLEN CROCKETT</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |  | 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>  |  | 17. INFORMANT Address<br><u>OLIVER THOMAS - CRISFIELD MD</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Died during sleep</u><br><u>434.4</u> DUE TO <u>Natural causes</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Legs swollen - Organic Heart Disease</u><br>DUE TO (c) <u>Legs swollen - Organic Heart Disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u><br>INTERVAL BETWEEN ONSET AND DEATH <u></u> |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. City or town (County) (State)<br><u>Crusfield</u> <u>San Md</u>                              |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Wm H Goullbourn</u>   |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type)  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 22b. DATE THEREOF<br><u>MAR-24-1960</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>CRISFIELD</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>CRISFIELD MD</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>L. S. Webster Crisfield, Md</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 28 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - EASTERN IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is divided into several horizontal sections with various labels and checkboxes.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DETAILED MEDICAL HISTORY AND EXAMINATION FINDINGS: \_\_\_\_\_

SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_